

PLEASE  
DO NOT  
STAPLE  
IN THIS  
AREA

PICA

## HEALTH INSURANCE CLAIM FORM

PICA

|  |  |   |  |
|--|--|---|--|
| 1. MEDICARE <input type="checkbox"/> (Medicare #) <input type="checkbox"/> (Medicaid #) <input type="checkbox"/> (Sponsor's SSN) <input type="checkbox"/> (VA File #) <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER <input type="checkbox"/> (ID) |  | 1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)   |  |
| 2. PATIENT'S NAME (Last Name, First Name, Middle Initial)  |  | 3. PATIENT'S BIRTH DATE<br>MM DD YY<br>SEX M <input type="checkbox"/> F <input type="checkbox"/>  |  |
| 5. PATIENT'S ADDRESS (No., Street)   |  | 6. PATIENT RELATIONSHIP TO INSURED<br>Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>   |  |
| CITY   |  | 7. INSURED'S ADDRESS (No., Street)  |  |
| STATE  |  | CITY  |  |
| ZIP CODE   |  | STATE   |  |
| TELEPHONE (Include Area Code)<br>( )   |  | ZIP CODE  |  |
| TELEPHONE (INCLUDE AREA CODE)<br>( )   |  | 11. INSURED'S POLICY GROUP OR FECA NUMBER   |  |
| 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)  |  | 10. IS PATIENT'S CONDITION RELATED TO:<br>a. EMPLOYMENT? (CURRENT OR PREVIOUS)<br><input type="checkbox"/> YES <input type="checkbox"/> NO<br>b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO<br>c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| a. OTHER INSURED'S POLICY OR GROUP NUMBER  |  | a. INSURED'S DATE OF BIRTH<br>MM DD YY<br>SEX M <input type="checkbox"/> F <input type="checkbox"/>   |  |
| b. OTHER INSURED'S DATE OF BIRTH<br>MM DD YY<br>SEX M <input type="checkbox"/> F <input type="checkbox"/>  |  | b. EMPLOYER'S NAME OR SCHOOL NAME   |  |
| c. EMPLOYER'S NAME OR SCHOOL NAME  |  | c. INSURANCE PLAN NAME OR PROGRAM NAME  |  |
| d. INSURANCE PLAN NAME OR PROGRAM NAME   |  | 10d. RESERVED FOR LOCAL USE   |  |
| 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.<br><br>SIGNED _____ DATE _____  |  |   |  |
| 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.<br><br>SIGNED _____  |  |   |  |

|   |  |   |  |
|---|--|---|--|
| 14. DATE OF CURRENT: MM DD YY   |  | ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)                          |  |
| 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY                    |  | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION<br>FROM MM DD YY TO MM DD YY     |  |
| 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE   |  | 17a. I.D. NUMBER OF REFERRING PHYSICIAN   |  |
| 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES<br>FROM MM DD YY TO MM DD YY          |  | 20. OUTSIDE LAB? \$ CHARGES<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 19. RESERVED FOR LOCAL USE  |  | 22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.  |  |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) |  | 23. PRIOR AUTHORIZATION NUMBER  |  |

| A                  |    | B                |    | C               |    | D   |          | E              |  | F          |  | G             |  | H                 |  | I   |  | J   |  | K                      |  |
|--------------------|----|------------------|----|-----------------|----|---|----------|----------------|--|------------|--|---------------|--|-------------------|--|-----|--|-----|--|------------------------|--|
| DATE(S) OF SERVICE |    | Place of Service |    | Type of Service |    | PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) |          | DIAGNOSIS CODE |  | \$ CHARGES |  | DAYS OR UNITS |  | EPSDT Family Plan |  | EMG |  | COB |  | RESERVED FOR LOCAL USE |  |
| From               | To |                  |    |                 |    | CPT/HCPCS   | MODIFIER |                |  |            |  |               |  |                   |  |     |  |     |  |                        |  |
| MM                 | DD | YY               | MM | DD              | YY |   |          |                |  |            |  |               |  |                   |  |     |  |     |  |                        |  |
| 1                  |    |                  |    |                 |    |   |          |                |  |            |  |               |  |                   |  |     |  |     |  |                        |  |
| 2                  |    |                  |    |                 |    |   |          |                |  |            |  |               |  |                   |  |     |  |     |  |                        |  |
| 3                  |    |                  |    |                 |    |   |          |                |  |            |  |               |  |                   |  |     |  |     |  |                        |  |
| 4                  |    |                  |    |                 |    |   |          |                |  |            |  |               |  |                   |  |     |  |     |  |                        |  |
| 5                  |    |                  |    |                 |    |   |          |                |  |            |  |               |  |                   |  |     |  |     |  |                        |  |
| 6                  |    |                  |    |                 |    |   |          |                |  |            |  |               |  |                   |  |     |  |     |  |                        |  |

|  |  |                           |  |  |  |                     |  |   |  |                    |  |            |  |  |  |
|--|--|---------------------------|--|--|--|---------------------|--|---|--|--------------------|--|------------|--|--|--|
| 25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>  |  | 26. PATIENT'S ACCOUNT NO. |  | 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO |  | 28. TOTAL CHARGE \$ |  | 29. AMOUNT PAID \$  |  | 30. BALANCE DUE \$ |  |            |  |  |  |
| 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) |  |                           |  | 32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)                 |  |                     |  | 33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # |  |                    |  |            |  |  |  |
| SIGNED _____   |  |                           |  | DATE _____   |  |                     |  | PIN# _____  |  |                    |  | GRP# _____ |  |  |  |